No. 91-226

IN THE

Supreme Court of the United States

OCTOBER TERM, 1991

KELLY KARE, LTD.; JOAN C. KELLY; KEVIN MCNULLA, on behalf of himself and all others similarly situated; and CHARLOTTE COHEN, on behalf of herself and all others similarly situated,

Petitioners,

v.

ANDREW P. O'ROURKE, Westchester County Executive; WESTCHESTER COUNTY; WESTCHESTER COUNTY DEPARTMENT OF SOCIAL SERVICES; JOHN J. ALLEN or his successor, Commissioner of the Westchester County Department of Social Services ("WCDSS"); S. REITANO, First Deputy Commissioner WCDSS; PHYLLIS SHEARER, Deputy Commissioner WCDSS; JOSEPH J. CAMPANELLA, Program Coordinator of WCDSS; JOSEPH J. LOSCRI, Accountant WCDSS; PATRICIA QUIRK, Supervising Examiner WCDSS; ADRIENNE YOUNG, Program Coordinator of WCDSS; MS. CALIFANO, WCDSS Supervisor; CINDY CAPONE, WCDSS Personal Care Worker; and DONALD WILLIAMS, WCDSS Caseworker,

Respondents.

Petition for a Writ of Certiorari to the United States Court of Appeals for the Second Circuit

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PETITION FOR A WRIT OF CERTIORARI

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QUESTIONS PRESENTED

1. Did Congress guarantee Medicaid patients the right to choose any qualified provider of Medicaid services without governmental interference, or may local agency officials arbitrarily force the transfer of Medicaid patients from a qualified provider?

2. In view of Medicaid's "freedom of choice" provision, does the New York statute mandating "procedural standards" for revocation of a provider's "qualification for participation" in the Medicaid program create a constitutionally-protected property interest in the provider's continued participation in the Medicaid program?

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OPINIONS BELOW

The opinion of the court of appeals (1a),[1] holding that petitioner Medicaid recipients do not have a cognizable right to continue receiving services from their qualified provider of choice and that their provider does not have a property interest in continued Medicaid participation, is reported at 930 F.2d 170 (2d Cir. 1991). The opinion of the district court (16a) is reported at 751 F. Supp. 1154 (S.D.N.Y. 1990).

JURISDICTION

The judgment of the court of appeals affirming the district court was entered on April 5, 1991 (1a). On May 14, 1991, the court of appeals entered an order denying the petition for rehearing (24a). This Court has jurisdiction to review the judgment of the court of appeals by writ of certiorari pursuant to 28 U.S.C. § 1254(1).

CONSTITUTIONAL PROVISIONS, STATUTES, AND REGULATIONS INVOLVED

Petitioners' claims arise under the freedom of choice provision of the federal Medicaid law, which provides:

> any individual eligible for medical assistance . . . may obtain such assistance from any institution, agency, community pharmacy, or person, qualified to perform the service or services required . . . who undertakes to provide him such services. . . .

42 U.S.C. § 1396a(a)23(A) (25a); the federal regulation promulgated thereunder, 42 C.F.R. § 431.51 (26a-27a); the New York statute mandating the promulgation of "procedural standards" governing actions that adversely affect a provider's "qualification for participation" in the Medicaid program, N.Y. SOC. SERV. LAW § 364(2)(b) (27a-28a); the due process clause of the

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[1] References to the Appendices hereto are cited as (—a).

Fourteenth Amendment, U.S. CONST. amend. XIV, § 1 (25a); and 42 U.S.C. § 1983 (25a-26a), all of which are set forth in Appendix D hereto. Respondents' actions against petitioners and the Second Circuit's decision herein were based on a state regulation, N.Y. COMP. CODES R. & REGS. tit. 18, § 504.7(a) (28a), that purports to authorize termination of a qualified provider's Medicaid participation "without cause."

STATEMENT OF THE CASE

Soon after creating the Medicaid program in 1965, Congress recognized a need to insure that beneficiaries of the Medicaid program have the same freedom to select a doctor or other service provider as do wealthy Americans. To guarantee that the right to select a qualified service provider would remain free of any governmental interference, Congress specifically added the "freedom of choice provision" in 1967 to insure Medicaid patients the absolute right to select any qualified Medicaid provider of their choice. 42 U.S.C. § 1396a(a)23(A). New York, as part of its state plan, N.Y. SOC. SERV. LAW §§ 363-369-j, enacted a law in 1977 protecting a provider's "qualification for participation" in the Medicaid program from being adversely affected unless certain "procedural standards" are followed and a "determination" is made that the provider is incompetent, fails to meet program standards, or threatens public health and safety. N.Y. SOC. SERV. LAW § 364(2)(b).

In 1987, the New York State Department of Social Services ("DSS") promulgated a regulation, N.Y. COMP. CODES R. & REGS. tit. 18, § 504.7(a), that purports to authorize termination of a provider's participation in the program without cause and without any process. Pursuant to this regulation, respondents require all Medicaid providers, including petitioner Kelly Kare, Ltd. ("Kelly Kare"),[2] to sign a Medicaid reimbursement form contract

[2] Kelly Kare has no parent or subsidiary companies. Sup. Ct. R. 29.1.

allowing for the provider's termination from the program by county officials without cause and without process. This controversy arose solely because respondents exercised their claimed right to terminate Kelly Kare's continued participation for *no reason whatsoever*. Since respondents openly admitted that they acted without affording petitioners any process, the Second Circuit squarely confronted the issue of whether a provider of Medicaid services has a right to continued participation in the Medicaid program (2a-3a). In rejecting petitioners' claims, the Second Circuit departed from the precise language enacted by Congress, and instead engrafted a new requirement of "Medicaid participation" to the freedom of choice provision (14a). Construing the complementary provisions of federal and state law, the Second Circuit held that even though respondents terminated Kelly Kare's Medicaid reimbursement contracts "without cause," Kelly Kare's patients had no right to remain with their chosen qualified provider and Kelly Kare could no longer participate in the Medicaid program in the county (nor challenge its dismissal), even though it was qualified to participate and had accepted respondents' rates for 1991. Petitioners may not complain, the court held, because no process is due.

A. The Termination of Kelly Kare's Medicaid Participation

Petitioner Kelly Kare is a qualified Medicaid provider duly licensed by New York State and has provided personal care services to indigent, disabled Medicaid recipients since 1987 under Titles XIX and XX of the Social Security Act, 42 U.S.C. § 1396 *et seq.*[3] DSS regulates

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[3] The Medicaid program is funded primarily by the federal government, with funding also coming from individual states and municipalities. Federal and state expenditures on Medicaid for about 27 million low-income people amounted to $72 billion in 1990 alone and are estimated to rise to $200 billion by 1996. S. Rich, *Task Force Says Medicaid Costs May Reach $200 Billion in 1996*, Washington Post, July 11, 1991, at A16, col. 1. New York's con-

the Medicaid program pursuant to the state plan and makes payments directly to providers. The Westchester County Department of Social Services ("WCDSS") locally administers the Title XIX and XX programs for home health care services by contracting with several dozen providers such as Kelly Kare in Westchester County, New York.

On October 31, 1990, after Kelly Kare had accepted WCDSS's Medicaid reimbursement rates for 1991, respondents formally notified Kelly Kare that its Medicaid reimbursement contracts for 1990 would be terminated effective November 30, 1990, and that WCDSS would not renew its reimbursement contracts for 1991. The termination letter cited a provision in the contracts that purported to authorize termination "without cause" on thirty days notice.[4] Thereafter, WCDSS sent form letters to all of Kelly Kare's Medicaid patients, petitioner McNulla class, advising them that Kelly Kare would no longer be

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tribution to Medicaid for fiscal year 1990 was $3.9 billion. Pallarito, *N.Y., N.J. governors bite into Medicaid funds*, Modern Healthcare 10 (Feb. 4, 1991).

Last year, New York spent almost $2.1 billion on home health care—roughly 80 percent of all the Medicaid dollars in the country devoted to such care. E. Kolbert, *New York's Medicaid Costs Surge, But Health Care for the Poor Lags*, N.Y. Times, Apr. 14, 1991, at 26, col. 3. In Westchester County alone, the federal government is slated to expend about $223 million for Medicaid costs in 1991.

[4] DSS regulations purport to authorize such a termination. *See* N.Y. COMP. CODES R. & REGS. tit. 18, § 504.7(a) ("A provider's participation in the program may be terminated by either the provider or the department upon 30 days' written notice to the other without cause."). *Cf. id.* at § 504.7(b) ("A provider's participation in the program may be terminated, suspended or restricted for a reasonable period of time if the department finds that the provider has engaged in an unacceptable practice as set forth in Part 515 of this Title. A provider whose participation is so terminated, suspended or restricted is entitled to *notice and an opportunity to be heard* in accordance with Part 515 of this Title.") (emphasis added).

providing services to them as of November 30, 1990, and that WCDSS would be reassigning their cases to a different personal care agency. WCDSS representatives then spoke to individual patients, threatening them with loss of their Medicaid benefits if they did not immediately change providers. Although some patients subsequently asked to change service providers, most of the McNulla class refused to change home health care agencies by the cutoff date.

WCDSS representatives also contacted Kelly Kare's employees, petitioner Cohen class, to inform them that they would be out of a job on December 1, 1990 if they did not immediately go to work for one of the agencies competing with Kelly Kare. WCDSS further informed the competing agencies of the imminent termination of Kelly Kare's reimbursement contracts and provided them with the names of Kelly Kare's patients and employees. WCDSS told the competing agencies that they should contact Kelly Kare's patients and employees to arrange for a change of service providers. The competing agencies then began to contact Kelly Kare's patients and employees for that purpose. Since almost all of Kelly Kare's infrastructure is located in Westchester County and approximately 75% of its patients were dependent upon Medicaid for their health care, respondents' actions threaten Kelly Kare's existence as a viable entity.

Subsequent to receiving the termination letter, petitioner Joan C. Kelly, president of Kelly Kare, repeatedly but unsuccessfully attempted to ascertain some reason for the termination and the actions that would be required for rescission thereof. Despite the severe consequences of the termination, petitioners have never been provided with any reason for the termination of the Medicaid reimbursement contracts, nor was Kelly Kare afforded any opportunity to present its case or to correct any alleged deficiencies in its performance. Respondents claim that

they need not provide any reason for the contract terminations or afford any process to petitioners.[5]

B. Decisions of the Courts Below

On November 19, 1990, petitioners commenced this action in the United States District Court for the Southern District of New York and simultaneously moved, *inter alia*, for a preliminary injunction to enjoin respondents from taking any action to transfer members of the McNulla class to other providers of personal care services and from terminating Kelly Kare's Medicaid participation in Westchester County without due process on the grounds that 42 U.S.C. § 1396(a)23(A) confers a right, enforceable under 42 U.S.C. § 1983, upon the members of the McNulla class to receive Medicaid services from any qualified provider of their choice without governmental interference and that New York Social Services Law § 364(2)(b) confers a property right upon Kelly Kare to participate in the Medicaid program. Jurisdiction of the district court was invoked pursuant to U.S. CONST. art. III, § 2 and 28 U.S.C. §§ 1331, 1343 (3, 4). The district court (Goettel, J.) denied petitioners' preliminary injunction motion, holding that Medicaid recipients "have no property right to demand a specific Medicaid provider" (21a) and that no property interest on behalf of their provider was implicated because "Kelly Kare's status as a Medicaid provider is not threatened—Westchester County has simply declined to renew its contract" (21a).

The United States Court of Appeals for the Second Circuit issued an injunction pending appeal continuing Kelly Kare's contract and thus permitted the members

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[5] Neither Kelly Kare nor Joan C. Kelly received any prior notice or warning of respondents' actions. After commencement of the instant litigation, respondents John J. Allen and Joseph J. Campanella refused to answer any deposition questions concerning the reasons for the contract terminations.

of the McNulla class to continue receiving services from Kelly Kare through the end of the then existing contract term and into the beginning of the next year. On January 9, 1991 after oral argument of the appeal, the Second Circuit dissolved its injunction and the members of the McNulla class were immediately forced by respondents to switch to other Medicaid providers.[6] On April 5, 1991, the Second Circuit affirmed the district court, rejecting the McNulla class's claim on the ground that:

> No cognizable property interest can arise in the Medicaid recipient unless the provider is both qualified *and participating* in the Medicaid program.

(14a) (emphasis added). While conceding that "there may be a property interest in a provider's status as a qualified health-care provider" (10a), the Second Circuit rejected Kelly Kare's claim on the ground that New York Social Services Law § 364(2)(b) did not confer a property interest on Kelly Kare to actually participate in the Medicaid program (10a-11a).[7] Thus, the Second Circuit determined that respondents' termination "without cause" of Kelly Kare's Medicaid reimbursement contracts legally deprived the members of the McNulla class of their right to receive medical services from the qualified provider of their choice and properly cut off Kelly Kare's participation in the Medicaid program, despite its qualification to participate.

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[6] In respondents' haste to force Kelly Kare out of business, numerous patients were left without any service provider, and Kelly Kare was asked, and did, provide services to them through January 11, 1991. As a result of the Second Circuit's lifting of its injunction, the majority of patients were transferred to competing home care agencies, others were forced to enter nursing homes, and ten patients have died.

[7] On June 18, 1991, the Second Circuit held that Section 364(2)(b) does *not* confer a property interest in a provider's status as qualified. *Senape v. Constantino*, No. 90-7677, slip op. at 4 (2d Cir. 1991) (available on Westlaw).

REASONS FOR GRANTING THE WRIT

The Court should grant certiorari in this case because the Second Circuit has decided an important question of federal law concerning the rights of all Medicaid patients to select their own qualified provider in a way that conflicts with a specific congressional mandate and this Court's decision in *O'Bannon v. Town Court Nursing Center*, 447 U.S. 773 (1980). Sup. Ct. R. 10.1(c). The Second Circuit's decision limiting the freedom of choice rights of Medicaid recipients also conflicts with the Eleventh Circuit's decision in *Silver v. Baggiano*, 804 F.2d 1211, 1217-18 (11th Cir. 1986) (Medicaid recipients have enforceable rights to receive care from the Medicaid provider of their choice), and its decision concerning a Medicaid provider's property interest in continued Medicaid participation conflicts with the decision of the Seventh Circuit in *Hathaway v. Mathews*, 546 F.2d 227, 232 (7th Cir. 1976) (Medicaid provider's participation cannot be terminated without providing due process). Sup. Ct. R. 10.1(a). Since neither the patients nor the provider herein was afforded any process before or after respondents determined that Kelly Kare could no longer provide services for the McNulla class, this case presents a clear opportunity for the Court to determine (a) whether Medicaid patients or their provider have any meaningful federal rights to protect against arbitrary local governmental action and (b) whether Congress intended the expenditure of billions of federal dollars on health care each year to be wholly outside the purview of the federal courts.

I. THE SECOND CIRCUIT'S DECISION NULLIFIES MEDICAID RECIPIENTS' FREEDOM TO CHOOSE AMONG QUALIFIED PROVIDERS

Eleven years ago this Court established that Medicaid recipients have the unfettered right to continued benefits to pay for care furnished by the qualified provider of their choice. *O'Bannon v. Town Court Nursing Center*,

447 U.S. 773, 786 (1980).[8] Thus, until the Second Circuit's decision herein, Medicaid recipients had "the right to choose among a range of qualified providers, without government interference" and "an absolute right to be free from government interference with the choice to remain in a home that continues to be qualified." *O'Bannon*, 447 U.S. at 785. *See also Silver v. Baggiano*, 804 F.2d 1211, 1217-18 (11th Cir. 1986).

This result flowed directly from the "freedom of choice" provision enacted by Congress:

> any individual eligible for medical assistance . . . may obtain such assistance from *any institution*, agency, community pharmacy, or person, *qualified* to perform the service or services required . . . who undertakes to provide him such services. . . .

42 U.S.C. § 1396a(a)23(A) (emphasis added).[9] This enactment vests each Medicaid recipient with a broad right to resist transfers ordered by the government unless the government establishes the provider's noncompliance with program participation standards. *Id.* at 791 (Blackmun, J., concurring).

The legislative history of the freedom of choice provision demonstrates that Congress intended such a broad right:

> Under the current provisions of law, there is no requirement on the State that recipients of medical assistance under a State title XIX program shall have freedom in their choice of medical institution or medical practitioner. In order to provide this free-

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[8] *O'Bannon* construed the unfettered choice to be limited to "qualified" providers, holding that Congress did not intend to confer a right on Medicaid recipients to receive services from unqualified providers.

[9] Respondents have not claimed that any of the exceptions to the free choice provision (*see* 42 U.S.C. §§ 1396a(g), 1396n) apply herein.

> dom, a new provision is included in the law to require States to offer this choice. Effective July 1, 1969, States are required to permit the individual to obtain his medical care *from any institution, agency, or person, qualified to perform the service or services*, including an organization which provides such services or arranges for their availability on a prepayment plan. Under this provision, *an individual is to have a choice from among qualified providers of service.* Inasmuch as States may, under title XIX, set certain standards for the provision of care, and may establish rates for payment, it is possible that some providers of service may still not be willing or considered qualified to provide the services included in the State plan. This provision does not obligate the State to pay the charges of the provider without reference to its schedule of charges, or its standards of care.

S. REP. NO. 744, 90th Cong., 1st Sess. 183 (emphasis added), *reprinted in* 1967 U.S. CODE CONG. & ADMIN. NEWS 3021. *See also* 1967 U.S. CODE CONG. & ADMIN. NEWS at 2868, 3137, 3211. Thus, Congress intended to allow Medicaid patients to choose their own provider as long as the provider met the state's standards of care and was willing to accept the state's schedule of charges for the services rendered. It is undisputed that Kelly Kare satisfies both of these requirements.

After passage of the freedom of choice provision, the Department of Health, Education, and Welfare ("HEW") promulgated a regulation implementing the provision:

> A State plan for medical assistance under title XIX of the Social Security Act must provide that any individual eligible for medical assistance under the plan may obtain the services available under the plan from any institution, agency, pharmacy, or practitioner . . . which is qualified to perform such services. This provision does not prohibit the State

> agency from establishing the fees which will be paid to providers for furnishing medical and remedial care available under the plan or from setting reasonable standards relating to the qualifications of providers of such care.

35 Fed. Reg. 8732 (1970) (originally codified at 45 C.F.R. § 249.11; now codified, as amended, at 42 C.F.R. § 431.51). *See also Bay Ridge Diagnostic Laboratory, Inc. v. Dumpson*, 400 F. Supp. 1104, 1107-08 (E.D.N.Y. 1975) ("HEW—consistent with the statements in the House and Senate Reports—has always interpreted Section 1396a(a)(23) to assure freedom of choice as to all qualified providers of medical services willing to render services in accordance with the fee schedules established by the state."). Accordingly, there can be no dispute over the meaning of the freedom of choice provision. The provision itself, its legislative history, and the regulations promulgated thereunder are all clear and unambiguous—Medicaid recipients must be permitted to choose any qualified provider who is willing to accept the state's reimbursement rates.

Despite the clarity of this congressional mandate, the Second Circuit misread *O'Bannon* and dismissed the freedom of choice provision as "semantic" (14a). According to the Second Circuit, the provider's qualification to participate in the Medicaid program is not enough—the provider must also be "participating" in Medicaid, *i.e.*, be offered a Medicaid reimbursement contract by the locality where patients desire the provider's services (14a-15a). The freedom of choice provision has no such requirement. To import one by a judicial rewriting of the statute, as the Second Circuit has done, nullifies the provision that is purportedly being construed. The only reason Kelly Kare can be said to be "not participating" in the Medicaid program is that a local agency, WCDSS, has decided to exclude Kelly Kare for no reason whatsoever. This is

the type of arbitrary conduct that Congress specifically forbade.[10]

Kelly Kare certainly desires to participate in the Medicaid program. It is qualified to do so and has accepted WCDSS's reimbursement rates for 1991. The members of the McNulla class desire to have Kelly Kare provide Medicaid services to them. Thus, Kelly Kare has met all of the standards for participation in the Medicaid program. Once a Medicaid provider satisfies these conditions, Medicaid recipients have the right to receive Medicaid services from that provider. 42 U.S.C. § 1396a(a)23(A).

The Second Circuit's addition of "and participating" to the freedom of choice provision limits the absolute right of Medicaid patients to select *any* qualified provider and effectively vests local officials with authority to control which providers may be selected by the poor. Now, governmental interference in the Medicaid recipients' choice of provider, if framed as a "without cause" termination of the provider's Medicaid participation, is wholly beyond the purview of the federal courts.

The result in *O'Bannon*, that patients did not have a right to choose a provider that had been determined *unqualified*, *O'Bannon*, 447 U.S. at 785-86, is distinguishable herein because, as the Second Circuit found, Kelly Kare is qualified (12a). Thus, this case does not raise any question as to whether a state may establish reasonable standards of patient care that are binding on all providers participating in the Medicaid program. If the Second Circuit's decision is permitted to stand, however, Medicaid patients will not even have the right to choose among all *qualified* Medicaid providers since that right will now be limited by the unreviewable acts of govern-

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[10] Under the Second Circuit's decision, WCDSS could eliminate all or all but one of the providers in the county—leaving all Medicaid recipients with no choice.

ment officials who do not need to demonstrate the provider's noncompliance with Medicaid's standards. Forcing a recipient to switch from a qualified provider abrogates the recipient's right to be free from government interference with the choice to remain with a provider that continues to be qualified. *O'Bannon*, 447 U.S. at 785.[11]

The state regulation authorizing arbitrary forced transfers—namely N.Y. COMP. CODES R. & REGS. tit. 18, § 504.7(a)—cannot stand if New York is to be deemed in compliance with federal Medicaid requirements. *See Harris v. McRae*, 448 U.S. 297, 301 (1980) ("Although participation in the Medicaid Program is entirely optional, once a State elects to participate, it must comply with the requirements of Title XIX."); *Silver v. Baggiano*, 804 F.2d 1211, 1215 (11th Cir. 1986) (Medicaid recipients may bring § 1983 action to obtain compliance on the part of the participating state). The regulation, as applied herein, annuls recipients' federally guaranteed freedom to choose any qualified provider if local officials do not want recipients to receive services from their provider of choice, even if the provider is qualified and willing to participate in the Medicaid program.

Contrary to the suggestion of the Second Circuit (15a), the freedom of choice provision is not an indirect Medicaid benefit unenforceable by recipients. *Cf. O'Bannon*, 447 U.S. at 786. Rather, *O'Bannon* states: "The net effect of these direct benefits is to give the patients an opportunity to obtain medical services from providers of their choice that is comparable, if not exactly equal, to the opportunity available to persons who are financially independent." *Id.* The "indirect benefits" to which the

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[11] Such transfers also impose unnecessary trauma on patients. *See Bumpus v. Clark*, 681 F.2d 679, 683 (9th Cir. 1982), *opinion withdrawn as moot*, 702 F.2d 826 (9th Cir. 1983); *Yaretsky v. Blum*, 629 F.2d 817, 821 (2d Cir. 1980), *rev'd on other grounds*, 457 U.S. 991 (1982); *Bracco v. Lackner*, 462 F. Supp. 436, 445 (N.D. Cal. 1978); *Klein v. Mathews*, 430 F. Supp. 1005, 1009-10 (D. N.J. 1977).

O'Bannon Court referred are those that inure to the benefit of recipients due to the government's enforcement of minimum standards of care. *Id.* at 787. The members of the McNulla class, however, have not suffered a mere "incidental burden" on their freedom of choice rights; rather, they have suffered a deprivation of their express statutory right to choose their own qualified provider. The Second Circuit's intimation (15a) that only a deprivation of financial assistance infringes on protected interests contradicts Congress's intent, as expressed in the state Medicaid participation requirements. 42 U.S.C. § 1396a(a).

The Second Circuit stated that "a Medicaid recipient's freedom of choice rights are necessarily dependent on a provider's ability to render services" (14a). Kelly Kare, however, is fully capable of rendering services since it is licensed and qualified and has accepted WCDSS's rates for 1991. If the Second Circuit meant to suggest that Kelly Kare is unable to render Medicaid services because respondents terminated Kelly Kare's reimbursement contracts without cause, such "inability" is the evil Congress proscribed in the freedom of choice provision—an "inability" resulting solely from arbitrary local governmental interference in the McNulla class's free choice of provider.

The Second Circuit also stated that beneficiaries cannot establish a legitimate entitlement to benefits when the source of government benefits runs dry through legitimate state action (14a-15a). While such a proposition may be true if the program is terminated or funding is reduced, here the *source* of government benefits has not run dry. The McNulla class is still entitled to receive the same level of home health-care services pursuant to the Medicaid program and WCDSS is required to expend the same amount of funds whether or not Kelly Kare is the provider. Thus, allowing the McNulla class to fully enjoy its rights to continued benefits to pay for care furnished by Kelly Kare does not adversely affect respondents.

Moreover, *O'Bannon* clearly states that "a patient has a right to continued benefits to pay for care in the qualified institution of his choice. . . ." *Id.* at 786. Accordingly, respondents cannot force the members of the McNulla class to leave their chosen qualified provider without nullifying the freedom-of-choice rights of Medicaid patients and ignoring this Court's decision in *O'Bannon.*

II. NEW YORK MEDICAID PROVIDERS HAVE A PROPERTY INTEREST IN PARTICIPATING IN THE MEDICAID PROGRAM

Since federal law requires that Medicaid recipients be afforded the right to choose among qualified providers, a qualified provider—like Kelly Kare—must necessarily be entitled to participate in the Medicaid program. State law further mandates that a provider's qualified status may not be revoked except for cause. N.Y. SOC. SERV. LAW § 364(2)(b).

Specifically, the New York legislature created a property interest in a Medicaid provider's status as qualified —an interest that cannot be undercut by a non-statutory regulation authorizing termination without cause.[12] *Id. See also Schaubman v. Blum,* 49 N.Y.2d 375, 380, 402 N.E.2d 1133, 1135, 426 N.Y.S.2d 230, 233 (1980) (provider's Medicaid participation may be revoked "*in proper circumstances*") (emphasis added). While the New York legislature may not have been required to confer this property interest upon qualified Medicaid providers, it cannot constitutionally authorize the deprivation of such

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[12] It should be noted that only N.Y. COMP. CODES R. & REGS. tit. 18, § 504.7(a)—which purports to authorize termination of participation without cause—is inconsistent with the recognition of a property interest. All other relevant regulatory provisions provide for notice of deficiencies and some sort of opportunity for the provider to present its case. *See, e.g., id.,* § 504.5(e)(1) (notice of deficiencies and written review afforded); *id.,* § 515.7(g) (providing post-deprivation due process where provider subject to immediate sanctions).

an interest once conferred, without appropriate procedural standards. *Atkins v. Parker*, 472 U.S. 115, 128 (1985); *Arnett v. Kennedy*, 416 U.S. 134, 167 (1974); *see also Cleveland Bd. of Educ. v. Loudermill*, 470 U.S. 532, 539-41 (1985) (property is not defined by state procedures provided for its deprivation). Here, the state legislature has not even sought to authorize the deprivation without due process of a provider's property interest in Medicaid participation, but rather, a subordinate agency has attempted to do so.[13]

Moreover, the legislative history of Section 364(2)(b) demonstrates that the state legislature did not create a subclass of providers that are "qualified, but not entitled to participate" in the Medicaid program. The 1966 legislative history reveals a debate over which agency—the Department of Health or the Department of Social Welfare—should establish and administer the criteria for being qualified. As it was recognized that beneficiaries have the right to choose among qualified providers, the debate focused on which agency would establish and administer the qualification standards for service providers. As originally enacted, Section 364(2)(b) provided:

> The department of health shall be responsible for . . . establishing, maintaining and certifying to the department of social welfare standards for all non-institutional medical care and services rendered pursuant to this title . . . .

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[13] While the Second Circuit stated that "[t]he refusal by a social services district to enter a contract with a qualified provider in no way affects the status of the provider" (11a), the simple fact is that the McNulla class cannot receive Medicaid services from Kelly Kare and Kelly Kare cannot be reimbursed for providing them. Since providers are required to maintain offices and facilities in the counties where they perform services, the termination of Kelly Kare's local Medicaid participation is tantamount to forcing Kelly Kare out of business.

Bill Jacket, 1977 N.Y. Laws ch. 770 (Feb. 2, 1977). In 1977, Section 364(2)(b) was amended to specifically require that the Department of Health establish:

> procedural standards relating to the revocation, suspension, limitation or annulment of qualification for participation as a provider of care and services, on a determination that the provider is an incompetent provider of specific services or has exhibited a course of conduct which is either inconsistent with program standards and regulations or which exhibits an unwillingness to meet such standards and regulations, or is a potential threat to the public health or safety pursuant to section two hundred six of the public health law . . . .

N.Y. SOC. SERV. LAW § 364(2)(b). This amendment was enacted to require the State Health Department "to establish and maintain standards for non-institutional health care providers participating in the Medicaid program, including standards for the revocation, suspension or limitation of *provider status*." Bill Jacket, 1977 N.Y. Laws ch. 770, Ten-Day Bill, Budget Report on Bills (emphasis added).[14] There is no hint of a distinction between "qualification to participate" and actual "participation." If a provider is "qualified," neither Congress nor the New York legislature intended to leave actual "participation" to the whims of local agency officials.[15]

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[14] Other aspects of the legislative history similarly reveal that the Legislature intended to require procedural standards for *participation* in the Medicaid program. *See* Bill Jacket, 1977 N.Y. Laws ch. 770, Memorandum from David Solomon, N.Y.S. Health Planning Comm'n, to Judah Gribetz, dated June 29, 1977 ("The authority to promulgate rules is delegated to the Department of Health and revocation for cause of the registration of a facility is included."); *id.*, Letter from Charles B. Dorf, Chairman, Committee on Health, Community Services Society, to Judah Gribetz, dated June 29, 1977 ("Participation in the Medicaid program must be limited to providers willing and able to comply with specific performance criteria.")

[15] *See* 46 Fed. Reg. 48,525 at II(D) (1981) (42 U.S.C. § 1396n (a)2(B) "allows exceptions to the freedom of choice requirements

Without any legislative mandate, the Second Circuit decided that a qualified provider only has the right to *seek* Medicaid participation with localities (11a).[16] By holding that providers have no property interest in actually participating in the Medicaid program, the Second Circuit effectively held that the Medicaid participation of qualified providers may be terminated "without cause" and that qualified Medicaid providers may be barred from serving those Medicaid patients who choose them.[17] This clearly limits the choices of Medicaid recipients by effectively disqualifying their desired providers and by refusing to authorize reimbursement for Medicaid services performed by such providers. Local government officials are now free to award Medicaid contracts on any impermissible basis, including discriminatory animus, political patronage, or as a reward for campaign contributions or assistance. Fundamental decisions concerning the delivery of health care to the poor and the spend-

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for States to restrict, for a reasonable period of time, the participation of providers in their Medicaid programs. This restriction could be imposed, if, *after notice and opportunity for hearing*, the State determines that the provider in a significant number or proportion of cases, provided services to beneficiaries when such services were not medically necessary or of a quality not meeting professionally recognized standards of health care.") (emphasis added). *Accord* 42 C.F.R. § 431.54(f). DSS's "without cause" termination regulation does not comply with 42 C.F.R. § 431.54(f).

[16] Since Medicaid is an entitlement program, respondents have no discretion over whether Medicaid services should be provided or at what level—WCDSS will expend the same amount whether Kelly Kare provides the services or not. Unlike the situation in ordinary public contracts (*cf. S & D Maintenance Co. v. Goldin*, 844 F.2d 962 (2d Cir. 1988), Kelly Kare has a statutory *right* to continue participating in Medicaid and the McNulla class has a statutory *right* to choose Kelly Kare as its qualified Medicaid provider.

[17] This holding is a departure from the Second Circuit's own precedents establishing that Medicaid providers *have* a property interest in continued participation. *Patchogue Nursing Center v. Bowen*, 797 F.2d 1137, 1144 (2d Cir. 1986), *cert. denied*, 479 U.S. 1030 (1987); *Case v. Weinberger*, 523 F.2d 602, 606 (2d Cir. 1975).

ing of billions of dollars of taxpayer funds will now be shielded from all federal judicial scrutiny.

Further, the procedural due process that protects a provider's "qualification status" is chimerical if actual participation may be terminated without process or reason. Since federal law requires state Medicaid plans to allow recipients the freedom to choose among qualified providers, there was no occasion for the New York legislature to make a distinction between "qualification to participate" and actual "participation." Since Congress gave Medicaid recipients the right to select any qualified provider, the chosen provider must necessarily be entitled to participate. Nothing in the legislative history supports the distinction drawn by the Second Circuit.

Citing the regulation that purports to authorize a "without cause" termination and the identical contract provision, the Second Circuit stated: "[s]uch vast discretion over the conferral of a governmental benefit . . . is fatal to a claim of entitlement to that benefit" (11a).[18] However, in order to be determinative of Kelly Kare's interest, such discretion must be consistent with the property interest created by the underlying statute, Section 364(2)(b). That statute *mandates* the promulgation of "procedural standards" before a provider's qualification

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[18] In *701 Pharmacy Corp. v. Perales*, 930 F.2d 163 (2d Cir. 1991), the court rejected an equal protection challenge to the "without cause" termination regulation. In *Tekkno Laboratories, Inc. v. Perales*, 933 F.2d 1093 (2d Cir. 1991), the court held that a preliminary injunction enjoining New York's withholding of payment of Medicaid claims in violation of due process was barred by the Eleventh Amendment. Most recently, in *Senape v. Constantino*, No. 90-7677 (2d Cir. June 18, 1991), the court held that a medical doctor had no right to challenge DSS's decision not to reenroll him as a qualified Medicaid provider where such decision was made for the express purpose of defeating the doctor's right to an evidentiary hearing. Taken together, the four recent decisions of the Second Circuit erect a total bar to any federal court review of "without cause" terminations from the Medicaid program.

status is adversely affected and requires a "determination" that the provider is incompetent, fails to meet program standards, or threatens public health or safety. Section 364(2)(b) thus requires that the promulgated procedural standards be followed and that a "determination" be made. It does not permit an agency to add to the list of legislatively enumerated reasons for termination of qualified status by promulgating a regulation authorizing terminations "without cause." *See Patrolmen's Benevolent Ass'n v. City of New York*, 41 N.Y.2d 205, 208-09, 359 N.E.2d 1338, 1341, 391 N.Y.S.2d 544, 546 (1976) (where statute describes particular situations in which it is to apply, an irrefutable inference must be drawn that what is omitted or not included was intended to be omitted or excluded); N.Y. Statutes Law § 240 (*expressio unius est exclusio alterius* governs interpretation of New York statutes).[19]

If the Second Circuit's decision is permitted to stand, a county government agency will never be required to give any reasons for actions that affect the lives of Medicaid patients and may destroy legitimate businesses. Local officials will never have any reason to terminate providers "for cause," to give providers a chance to present their case, or to provide an opportunity to correct deficiencies since they may avoid a hearing and possible challenges to their actions simply by making all decisions "without cause." Just such a scenario unfolded in *Senape v. Constantino*, No. 90-7677, slip op. at 2 (2d Cir. June

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[19] A recent Second Circuit case construing Section 364(2)(b) states: "That DSS must issue regulations governing the 'for cause' termination of providers in no way precludes the Department from issuing other regulations reasonably necessary to advance the objectives of the program." *Senape v. Constantino*, No. 90-7677, slip op. at 4 (2d Cir. June 18, 1991). This interpretation of Section 364(2)(b) ignores New York rules of statutory construction and renders the statute meaningless. The state legislature's creation of an interest that can only be terminated for cause may not be overridden by a regulation authorizing termination without cause.

18, 1991), where a provider was suspended from the Medicaid program on the grounds that its continued participation would allegedly endanger recipients' health or welfare, but once the provider challenged the asserted grounds, DSS withdrew that basis and refused to reenroll the provider without providing any reason. *See also Bezar v. New York State Dep't of Social Services*, 151 A.D.2d 44, 546 N.Y.S.2d 195 (3d Dep't 1989) (provider terminated "without cause" even though the state cited "unacceptable practices" as set forth in Part 515 of DSS regulations, which normally requires a hearing).

The Medicaid program—designed to provide Medicaid recipients with medical choices comparable to those available to persons who are financially independent (*O'Bannon*, 447 U.S. at 786)—will steadily worsen as the number of available providers shrinks because providers are discouraged or prevented from participating because of arbitrary governmental barriers. The Second Circuit's ruling will have the effect of cloaking government decisions in secrecy, encouraging political favoritism in the awarding of health service contracts, increasing the probability of mistakes, and undermining government accountability. It contravenes unambiguous legislative intent, encourages arbitrary governmental action that disrupts recipients' lives and destroys legitimate businesses, and undermines the future vitality of the Medicaid program. At a time when the nation's attention is focused on the health care system, petitioners urge the Court to grant certiorari to allow Medicaid recipients and providers to vindicate their statutory and constitutional rights in federal court.

CONCLUSION

For the reasons stated above, petitioners respectfully request that the petition for a writ of certiorari be granted to review the judgment and opinion of the United States Court of Appeals for the Second Circuit.

Dated: New York, New York
August 5, 1991

Respectfully submitted,

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APPENDICES

APPENDIX A

UNITED STATES COURT OF APPEALS
FOR THE SECOND CIRCUIT

No. 1106 August Term, 1990

(Argued: January 9, 1991 Decided: April 5, 1991)

Docket No. 90-9107

KELLY KARE, LTD., JOAN C. KELLY; KEVIN MCNULLA, on behalf of himself and all others similarly situated; and CHARLOTTE COHEN, on behalf of herself and all others similarly situated,

Plaintiffs-Appellants,

v.

ANDREW P. O'ROURKE, Westchester County Executive; WESTCHESTER COUNTY; WESTCHESTER COUNTY DEPARTMENT OF SOCIAL SERVICES; JOHN J. ALLEN, or his successor, Commissioner of the Westchester County Department of Social Services ("WCDSS"); S. REITANO, First Deputy Commissioner WCDSS; PHYLLIS SHEARER, Deputy Commissioner, WCDSS; JOSEPH J. CAMPANELLA, Program Coordinator of WCDSS; PATRICIA QUIRK, Supervising Examiner WCDSS; ADRIENNE YOUNG, Program Coordinator of WCDSS; MS. CALIFANO, WCDSS Supervisor; CINDY CAPONE, WCDSS Personal Care Worker; DONALD WILLIAMS, WCDSS Caseworker,

Defendants-Appellees.

Before: WINTER, ALTIMARI and McLAUGHLIN, *Circuit Judges.*

Plaintiffs, a Medicaid-sponsored home health-care provider and its patients and employees, moved to enjoin defendants from terminating the provider's Medicaid reimbursement contract. The district court (Goettel, J.) denied the preliminary injunction. *Held*: Provider has no property or liberty interest in continued, uninterrupted participation in the Medicaid program. Additionally, patients have no due process right to demand services of a provider that is not participating in the Medicaid program.

Affirmed.

James S. Frank (Vedder, Price, Kaufman, Kammholz & Day, New York, New York, Michael W. Sculnick and Neil A. Capobianco of counsel) *for Appellants.*

Frank Marocco (Westchester County Attorney's Office, White Plains, New York, Marilyn J. Slaaten, Westchester County Attorney, Carol L. Van Scoyoc, Deputy County Attorney, Westchester County Attorney, of counsel) *for Appellees.*

McLAUGHLIN, *Circuit Judge*:

The Westchester County Department of Social Services ("WCDSS") decided—without giving any reason—to terminate the Medicaid reimbursement contract of plaintiff Kelly Kare, Ltd. ("Kelly Kare"), a provider of health-care services to individuals who require medical assistance in their homes. Kelly Kare assails this as an unconstitutional deprivation of property and liberty because it limits Kelly Kare's status as a qualified Medicaid provider and because it strains Kelly Kare's professional reputation, without due process. Because it is clear that plaintiffs were afforded no process by WCDSS, we are

squarely confronted with the issue of whether a provider of Medicaid-sponsored health-care services has a right to continued and uninterrupted participation in the Medicaid program.

BACKGROUND

Medicaid is a medical assistance program created by Titles XIX and XX of the federal Social Security Act to provide indigents and the disabled with subsidized medical care. 42 U.S.C. § 1396 *et seq.* (1988). Although funding comes primarily from the federal government, it also comes from the individual states and, to a lesser degree, from municipalities and counties. Congress has delegated the authority to administer the Medicaid program to the states. As such, the states are responsible for licensing health-care providers and qualifying them for paticipation in the program.

The day-to-day administration of the Medicaid program is performed by local social services districts. Each district has the option to render the services directly or to contract with a qualified provider of Medicaid services to furnish the necessary medical assistance. N.Y. Soc. Serv. Law § 365(1)(d). If a district chooses the second alternative, the chosen provider is then entitled to be reimbursed for the legitimate health-care services that it renders to Medicaid-eligible patients.

Westchester County, a local social services district, has opted to provide Medicaid services through contracts with qualified providers. Kelly Kare, a qualified provider of home health care, renders housekeeping and other personal-care services.

In 1987, Kelly Kare entered into the first of a series of one-year contracts with WCDSS for reimbursement of Medicaid services. From year to year, the only salient difference in the contracts was the rate at which the providers would be reimbursed. The County's health-care providers would gather annually where WCDSS presented

them with the proposed rate schedule for the following year. Once the providers assented to the proposed rates, the contracts were sent off to WCDSS for approval.

At his deposition, John Allen, Commissioner of WCDSS, testified that if health-care providers agreed to the proposed rate schedules and kept their "filings" up to date—e.g., liability insurance, references, insurance coverage for their workers—they were usually awarded a new contract. Nothing in the record, however, indicates that simply because a party acceded to the proposed rates it became entitled to a contract with the County. In fact, the record establishes that several further steps had to be executed for the contract to become binding.

One clause in the reimbursement contract provides that the contract is terminable, without cause, upon thirty days' notice. This clause is authorized by a regulation of the New York State Department of Social Services, which states:

> A provider's participation in the program may be terminated by either the provider or the department upon thirty days' written notice to the other without cause.

18 N.Y.C.R.R. § 504.7(a). Neither the contract clause nor section 504.7(a) affords a hearing to the terminated provider.

On October 26, 1990, WCDSS invoked this contractual option and informed Kelly Kare that the 1990 reimbursement contract would be cancelled, without cause, effective November 30, 1990. Defendants then began informing Kelly Kare's patients and employees that the contract had been terminated and that, after November 30, 1990, Kelly Kare would no longer be reimbursed for any Medicaid-related services it rendered.

Defendants' decision to terminate Kelly Kare's contract was reached soon after Kelly Kare had agreed to

the proposed rate schedule for 1991. Defendant Joseph Campanella, Program Coordinator for WCDSS, requested proof from Kelly Kare that its employees were covered by a health-insurance plan. The record indicates that this was not the first request made for such information. Apparently, Joan Kelly, president of Kelly Kare, had been delinquent in providing this information in the past. Nevertheless, on September 16, 1990, Ms. Kelly visited Mr. Campanella's office and handed him a copy of a collective-bargaining agreement that had recently been negotiated between Kelly Kare and its employees. The agreement contained an employee health-insurance clause. Mr. Campanella told Ms. Kelly that he was unfamiliar with this type of agreement and that he would pass it along to the "legal department" to assure that Kelly Kare's employees were being afforded proper coverage. Just over one month later, Kelly Kare was informed that its Medicaid contract was being terminated, without cause. This, claims Kelly Kare, demonstrates that anti-union animus impermissibly motivated WCDSS to cancel the contract.

Upon commencement of this action, plaintiffs moved to enjoin defendants from terminating the contract without cause. Kelly Kare argued, as it does now, that New York's Social Services Law creates a property interest in those health-care providers that the state deems qualified to participate in the Medicaid program. *See* N.Y. Soc. Serv. Law § 364(2)(b). As such, Kelly Kare asserted that it was entitled to due process prior to being terminated from participation in Medicaid. Additionally, Kelly Kare contended that the without-cause termination stigmatized its reputation, thereby depriving it of a liberty interest without the requisite due process.

A separate group of plaintiffs, the "McNulla plaintiffs," several Kelly Kare patients, claimed, as they do now, that they had been deprived of their rights under the Medicaid program's so-called "freedom of choice" pro-

vision. *See* 42 U.S.C. § 1396a(a)23(A). They argued that since the Medicaid statute gives them the right to choose any qualified Medicaid provider, they must be allowed to choose Kelly Kare.

A third group of plaintiffs, the "Cohen plaintiffs," several Kelly Kare employees, contended, as they do now, that, along with Kelly Kare, their rights under the National Labor Relations Act ("NLRA") were violated by defendants' anti-union animus. *See* 29 U.S.C. § 158.

The district court denied plaintiffs' motion for a preliminary injunction. Judge Goettel dismissed Kelly Kare's property right claim as a basis for injunctive relief, citing the contract provision allowing for termination without cause. Because the action taken by WCDSS did not affect Kelly Kare's status as a qualified Medicaid provider, Judge Goettel held that any colorable property right stemming from section 364(2)(b) of New York's Social Services Law was not affected by the contract termination. Judge Goettel also rejected Kelly Kare's liberty-interest claim, finding that termination of a contract for no stated reason does not stigmatize a party to such a degree as to deprive it of a liberty interest.

The McNulla plaintiffs' claims were rejected on the ground that, while they had a right to continue receiving Medicaid benefits, they had no cognizable right to demand a specific provider. Finally, Judge Goettel held that plaintiffs' NLRA claims, to the extent that they might establish an impermissible motive for the termination of the contracts, were not supported by sufficient evidence to warrant injunctive relief.[1]

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[1] At the outset, we have considered plaintiffs' argument that they are entitled to a preliminary injunction because of defendants' violations of the NLRA. Plaintiffs contend that they have met the requirements of a less restrictive preliminary injunction standard. This lesser standard provides that, in addition to demonstrating irreparable harm, a party is entitled to a preliminary injunction upon a showing of *either* likelihood of success *or* sufficiently serious

This appeal followed. For the reasons stated below, we affirm.

DISCUSSION

Kelly Kare's Property Interest

Does section 364(2)(b) of New York's Social Services Law create a property interest in a qualified Medicaid provider's continued and uninterrupted participation in the program? If so, the provider is entitled to due process before termination from participation in the Medicaid Program.

Section 364(2)(b) states:

> The department of health shall be responsible for . . :
>
> > (b) establishing and maintaining standards for all non-institutional health care and services rendered pursuant to this title, including but not limited to procedural standards relating to the revocation, suspension, limitation or annulment of *qualification* for participation as a provider of care and services, on a determination that the provider is an incompetent provider of specific services or has exhibited a course of conduct which is either inconsistent with program standards and regulations or which exhibits an unwillingness to meet such standards and regu-

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questions going to the merits and a balance of the hardships in favor of the party seeking relief. *See Union Carbide Agricultural Products Co.* v. *Costle*, 632 F.2d 1014, 1017 (2d Cir. 1980), *cert. denied* 450 U.S. 996 (1981). We must disagree with plaintiffs' contention. We do not imply that plaintiffs would be barred from obtaining relief were they able to establish an impermissible motive behind defendants' actions. *See Golden State Transit Corp. v. City of Los Angeles*, 110 S. Ct. 444, 449-52 (1989) (*Golden State II*); *Golden State Transit Corp. v. City of Los Angeles*, 475 U.S. 608, 615-19 (1986) (*Golden State I*). We hold only that plaintiffs have failed to make a sufficient threshold showing to justify injunctive relief, even under the less restrictive standard.

> lations, or is a potential threat to the public health or safety pursuant to section two hundred six of the public health law . . . .

N.Y. Soc. Serv. Law § 364(2)(b) (emphasis added).

Kelly Kare argues that by enacting this statute the New Your State Legislature intended to create a property right in the "qualified provider" status; and, thus, once qualified, due process must be afforded in order to revoke or limit a provider's qualification. From this claim of right, Kelly Kare extrapolates that its *participation* in Medicaid—not simply its *qualification* to participate—is also a protected property interest that cannot be abridged without due process. We disagree.

A property interest does not exist solely because of the importance of the benefit to the recipient. Nor is the "unilateral expectation" of continued receipt of the benefit sufficient to establish a property interest. *Board of Regents v. Roth*, 408 U.S. 564, 577 (1972). To establish a property interest in continued participation in the Medicaid program, Kelly Kare must demonstrate "a legitimate claim of entitlement" to such uninterrupted participation. *Id.*; *see Perry v. Sindermann*, 408 U.S. 593, 599-601 (1972); *S & D Maintenance Co. v. Goldin*, 844 F.2d 962, 965-66 (2d Cir. 1988).

Property interests flow not from the Constitution itself, but from "existing rules or understandings that stem from an independent source such as state law. . . ." *Roth*, 408 U.S. at 577; *see RR Village Ass'n v. Denver Sewer Corp.*, 826 F.2d 1197, 1201 (2d Cir. 1987). Looking to state law, "we focus initially on the relevant statute, regulation, or contract establishing eligibility for the government benefit at issue." *Plaza Health Laboratories, Inc. v. Perales*, 878 F.2d 577, 581 (2d Cir. 1989). If the statute, regulation, or contract in issue vests in the state significant discretion over the continued conferral of that benefit, it will be the rare case that the recipient

will be able to establish an entitlement to that benefit. *Id.; RR Village Ass'n*, 826 F.2d at 1201-02.

On the other hand, when state law supports a party's legitimate claim of entitlement to a governmental benefit, that benefit cannot be stripped without procedural due process; and federal law determines what process is due. *See Cleveland Board of Education v. Loudermill*, 477 U.S. 532, 538-41 (1985); *RR Village Ass'n*, 826 F.2d at 1201. When a state-conferred benefit ripens into a property right, any procedures that the state establishes for the revocation of that interest must comport with the federal procedural due process requirements. *Loudermill*, 470 U.S. at 540-41; *Logan v. Zimmerman Brush Co.*, 455 U.S. 422, 431-32 (1982).

Kelly Kare argues that section 364(2)(b) creates a legitimate expectation of continued participation in the Medicaid program by a qualified Medicaid provider. As such, claims Kelly Kare, both the Department of Social Services' regulation 504.7(a), which allows for termination without cause, as well as the substantively similar contractual provision in issue, unconstitutionally limit this property right.

While we have addressed the issue of whether a health-care provider has a property interest in continued participation in the Medicaid program in the past, *compare Plaza Health Laboratories*, 878 F.2d at 582 (structure of New York's Medicaid laws suggest that a provider does not have a property interest in continued participation) *with Patchogue Nursing Center v. Bowen*, 797 F.2d 1137, 1144-45 (2d Cir. 1986) (providers maintain property interest in continued participation in Medicaid), *cert. denied*, 479 U.S. 1030 (1987) *and Case v. Weinberger*, 523 F.2d 602, 606 (2d Cir. 1975) (same), we have not yet squarely addresed it in this context. An examination of our earlier cases reveals that they are not necessarily inconsistent. Both *Patchogue Nursing* and *Case* involved situations totally dissimilar to the present

one, in which the institutional providers, i.e., nursing homes, were facing suspension or removal of their federal certification as qualified nursing homes. In *Plaza Health*, we focused on the structure of New York's regulatory scheme—which was modified after the decisions in *Patchogue Nursing* and *Case*—and opined that the State's retention of significant discretion in continuing a qualified provider's participation raised a doubt as to the existence of a property right in continued participation. Furthermore, in *Plaza Health*, we sidestepped the issue, because we determined that regardless of whether a property interest existed, sufficient process had been afforded to pass constitutional muster.

The present argument is a bit different from that in *Plaza Health*. Kelly Kare cites to New York's statutory scheme, as opposed to its regulatory scheme, in making its claim of entitlement. In essence, Kelly Kare argues that regulation 504.7(a) conflicts with section 364(2)(b) of New York's Social Services Law—which it claims creates a property right in continued participation—and is perforce unconstitutional. Kelly Kare claims that because section 364(2)(b) prescribes specific reasons for the Department of Health to revoke, limit, or terminate provider's qualification to participate in Medicaid, the Legislature intended that participation could be terminated only for one of these reasons. Absent such cause, claims Kelly Kare, participation by a qualified provider cannot be terminated. We disagree.

We discern in section 364(2)(b) no property interest in continued participation. Notwithstanding that there may be a property interest in a provider's status as a qualified health-care provider—a question we need not and do not reach—it is clear that nothing in section 364(2)(b) entitles Kelly Kare to uninterrupted participation in the program, i.e., a continuing reimbursement contract.

There is a critical difference between being declared a qualified health-care provider and being awarded a con-

tract to furnish health-care services. The refusal by a social services district to enter a contract with a qualified provider in no way affects the status of the provider. Such a disappointed provider remains free to seek a contract with a different social services district. Furthermore, the wording of section 364(2)(b) belies Kelly Kare's claim that it has a right to participate in the program. The statute specifically focuses on a provider's status as qualified; continuous participation is not addressed.

Kelly Kare has no cognizable property interest stemming either from the regulations or the contract. Both allow the government entity to terminate participation without cause. Such vast discretion over the conferral of a governmental benefit—namely, continued, uninterrupted participation in Medicaid—is fatal to a claim of entitlement to that benefit.[2] *See Plaza Health*, 878 F.2d at 581; *Walentas v. Lipper*, 862 F.2d 414, 419 (2d Cir. 1988), *cert. denied*, 490 U.S. 1021 (1989); *RR Village Ass'n*, 826 F.2d at 1201-02. We note that cases from the New York State courts interpreting the present regulatory scheme, including 18 NYCRR § 504.7(a), have concluded that no legitimate entitlement to continued participation exists. *See, e.g., Ray Pharmacy, Inc. v. Perales*, No. 41968, slip op. at 124 (1st Dep't Jan. 29, 1991); *Bezar v. New York State Department of Social Services*, 151 A.D.2d 44, 49, 546 N.Y.S.2d 195, 198 (3d Dep't 1989).

Furthermore, we are unimpressed by Kelly Kare's argument that it heightened its legitimate expectation of continued participation when it agreed to the proposed rate schedule for 1991. No contract arose because of Kelly Kare's assent to the new rates, and both the County

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[2] We observe that when this Court decided *Patchogue Nursing* and *Case*, New York's regulatory scheme did not provide for without-cause termination. Additionally, as previously stated, these cases related to decertification.

and the State certainly maintained significant discretion to refuse to enter into a final and binding contract.

We emphasize that defendants' action does not bear on Kelly Kare's status as a qualified provider. We hold only that section 364(2)(b) of New York's Social Services Law does not create a property interest in continued participation in the Medicaid program. Further, Kelly Kare has not, nor could it, point to anything in the regulations of the Department of Social Services or in the contract that would entitle it to continued and uninterrupted participation in Medicaid. Therefore, no property interest exists.

Kelly Kare's Liberty Interest

The next question is whether the termination of Kelly Kare's provider contract amounts to a deprivation of a liberty interest. Kelly Kare claims that the innuendo flowing from the without-cause termination is sufficiently stigmatizing to amount to a deprivation of a liberty interest. Again, we must disagree.

It is now a commonplace that an entity may have a liberty interest in its good name, and if its reputation is besmirched by governmental action, it may be entitled to a name-clearing hearing.[3] *See Wisconsin v. Constantineau*, 400 U.S. 433, 437-39 (1971) ("[w]here a person's good name, reputation, honor, or integrity is at stake because of what the government is doing to him, notice and an opportunity to be heard are essential"); *Quinn v. Syracuse Model Neighborhood Corp.*, 613 F.2d 438, 446 (2d Cir. 1980). The injured party's liberty is at stake when governmental action places "on him a stigma or other disability that foreclose[s] his freedom

[3] We are mindful of the Supreme Court's ruling that defamation alone does not raise a due process claim. *See Paul v. Davis*, 424 U.S. 693, 701-02 & 710-13 (1976). In light of our holding that Kelly Kare has completely failed to establish that any stigma attached to it, we do not consider this question.

to take advantage of other employment opportunities." *Roth*, 408 U.S. at 573. To prevail on such a liberty-interest claim, a plaintiff must establish that the information was stigmatizing, false, and publicized by the state actor. *Brandt v. Board of Cooperative Educational Services*, 820 F.2d 41, 43 (2d Cir. 1987); *Quinn*, 613 F.2d at 446; *Gentile v. Wallen*, 562 F.2d 193, 197 (2d Cir. 1977).

Kelly Kare has not begun to establish that defendants published any false statements that would stigmatize it. Defendants simply provided no reason for the termination. While the contract cancellation may have become public knowledge, we see nothing false or sufficiently stigmatizing flowing from this without-cause termination that would amount to a deprivation of a liberty interest. We cannot agree that the innuendo—if any—that stems from a without-cause termination is tantamount to a false accusation by defendants.

This Court has previously cautioned against extending overbroad constitutional protections to government contracts. *See S & D Maintenance Co.*, 844 F.2d at 970-71. A free-floating liberty interest cannot rest on speculation that negative implications will flow from a termination without cause. The supposed consequences, if any, are too attenuated from the state action. To recognize such a right would create a liberty-interest claim whenever a state actor exercised a contractual option to terminate a government contract without cause. This we refuse to do.[4]

Due Process Claims of the McNulla Class

We turn finally to the claim that the McNulla plaintiffs—Kelly Kare's patients—have been deprived without due process of their statutorily granted freedom to choose

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[4] We express no opinion as to the viability of a liberty interest claim stemming from a termination for cause pursuant to 18 N.Y.C.R.R. § 504.7(b).

among qualified Medicaid health-care providers. We find this claim to be without merit.

Pursuant to federal law, eligible Medicaid recipients are given a "freedom of choice" among qualified health-care providers. The relevant statute provides:

> [A]ny individual eligible for medical assistance (including drugs) may obtain such assistance from any institution, agency, community pharmacy, or person, *qualified* to perform the service or services required (including an organization which provides such services, or arranges for their availability, on a prepayment basis), who undertakes to provide him such services . . . .

42 U.S.C. § 1396a(a)(23)(A) (emphasis added). The McNulla plaintiffs argue that if Kelly Kare's status as a qualified provider had not been affected, they would have had a right to choose Kelly Kare as their provider, and that right has now been denied them without due process. While this argument has a certain semantic appeal, it misses the point.

Medicaid's freedom of choice provision is not absolute. *See O'Bannon v. Town Court Nursing Center*, 447 U.S. 773 (1980). In *O'Bannon*, the Supreme Court held that Medicaid-eligible nursing home patients did not have a vested right to choose a nursing home that was being decertified as a health-care provider. *Id.* at 785. The Court stated that the freedom of choice provision was intended to give beneficiaries "the right to choose among a range of *qualified* providers, without government interference." *Id.* (emphasis in original).

We read *O'Bannon* as holding that a Medicaid's recipient's freedom of choice rights are necessarily dependent on a provider's ability to render services. No cognizable property interest can arise in the Medicaid recipient unless the provider is both qualified and participating in the Medicaid program. When the source of government bene-

fits runs dry through legitimate state action, beneficiaries are hard-pressed to establish a legitimate entitlement to that benefit. *See O'Bannon*, 447 U.S. at 798 (Blackmun, J. concurring).

We therefore conclude that the McNulla plaintiffs do not have a property interest in their freedom to choose Kelly Kare as their provider because Westchester County has properly cancelled Kelly Kare's contract.

Additionally, the McNulla plaintiffs do not have a cognizable liberty interest in choosing Kelly Kare as their health-care provider. The *O'Bannon* Court distinguished between direct Medicaid benefits—financial assistance—and indirect ones—e.g., freedom of choice. The Court held that state action that incidentally burdens an indirect governmental benefit does not rise to the level of a deprivation of a liberty interest. *See id.* at 786-88.

The McNulla plaintiffs have suffered an incidental burden on their right to choose among qualified and participating health-care providers. Their direct benefits clearly have not been altered. They shall continue to receive government-sponsored home health assistance, albeit from a different provider. Such an incidental burden certainly does not infringe on any liberty interest.

Again, we conclude that the district court correctly determined that the McNulla plaintiffs had no property or liberty interest at stake, and, therefore, properly refused to enjoin defendants.

CONCLUSION

For the forgoing reasons, plaintiffs have no viable liberty or property interest claims; nor have they approached a threshold showing of a violation of the NLRA sufficient to justify a preliminary injunction. We conclude, therefore, that the district court did not abuse its discretion in refusing to order injunctive relief.

Affirmed.

APPENDIX B

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

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90 Civ. 7418 (GLG)

KELLY KARE, LTD.; JOAN C. KELLY; KEVIN MCNULLA, on behalf of himself and all others similarly situated; and CHARLOTTE COHEN, on behalf of herself and all others similarly situated,

Plaintiffs,

—against—

ANDREW P. O'ROURKE, Westchester County Executive; WESTCHESTER COUNTY; WESTCHESTER COUNTY DEPARTMENT OF SOCIAL SERVICES; JOHN J. ALLEN or his successor, Commissioner of the Westchester County Department of Social Services ("WCDSS"); S. REITANO, First Deputy Commissioner WCDSS; PHYLLIS SHEARER, Deputy Commissioner WCDSS; JOSEPH J. CAMPANELLA, Program Coordinator of WCDSS; JOSEPH LOSCRI, Accountant WCDSS; PATRICIA QUIRK, Supervising Examiner WCDSS; ADRIENNE YOUNG, Program Coordinator of WCDSS; MS. CALIFANO, WCDSS Supervisor; CINDY CAPONE, WCDSS Personal Care Worker; and DONALD WILLIAMS, WCDSS Caseworker,

Defendants.

OPINION

The plaintiff, Kelly Kare, Ltd., is a qualified Medicaid provider affording personal care services to indigent, disabled persons. Joan C. Kelly is its president and principal owner. The personal care services provided to Medicaid

recipients include homemaker and housekeeping services. A worker generally serves only a single recipient and, indeed, many recipients have two or more persons assigned to their care in order to provide all-day and weekend service. The other named plaintiffs in this action, who seek to be class representatives, are a recipient and an employee of Kelly Kare, Ltd.

The program, under which Kelly Kare provides personal care services to eligible recipients, is authorized by Title XIX and XX of the Social Security Act. *See* 42 U.S.C. § 1396 *et seq.* It is funded primarily by the federal government but also by state and county contributions. The New York State Department of Social Services regulates the program and makes payments to the personal care providers. Local counties administer the personal care services by, *inter alia*, contracting with licensed providers.

The Westchester County Department of Social Services contracted with Kelly Kare, among a number of others, to provide the personal care services to Medicaid-eligible residents in Westchester County. The contracts are on a calendar year basis and Kelly Kare has so contracted with Westchester since 1987. The state assigns a Medicaid management information system number to Kelly Kare and makes payments upon receiving appropriate invoices. The Kelly Kare contract with the County of Westchester is the only Medicaid contract which Kelly Kare has. It does have a number of individual clients who are not on welfare.

The contract between the County of Westchester and Kelly Kare provides that it may be terminated without cause upon thirty days notice. This conforms with the New York State regulations which allow such terminations. *See* 1e N.Y. Comp. Codes R & Regs. tit. 18, 504.7 (a). On or about October 26, 1990, the County notified Kelly Kare that its contract was being terminated, without cause, at the end of November. The contract, by its

terms, does not expire until the end of December.[1] The County has refused to state its reasons for terminating Kelly Kare's contract, taking the position that since it can do so without cause, it need not have a reason and, in any event, need not disclose it.[2] Immediately after notifying Kelly Kare, the County started advising Medicaid recipients serviced by Kelly Kare, as well as its employees, of the pending contract termination and the fact that governmental funds would not be thereafter subsidizing the program. The County contends that most of the patients have agreed to change agencies while Kelly Kare contends that most of the recipients have remained with them.[3] We do not deem this issue material since it is enough to say that some recipients have switched and some have not.

Plaintiffs then commenced the instant lawsuit challenging the impending termination of the contract, alleging that it violates various federal and constitutional rights of the plaintiffs. Simultaneously, they moved for preliminary injunctive relief. Two hearings were conducted.[4] While Kelly Kare asserts a number of

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[1] Kelly Kare argues that it has already contracted with the County for the year 1991 since it, along with other providers, agreed to proposed rates for that year in writing, which was then submitted by the County to the State for approval. That step, which is preliminary to the entering into of a contract, clearly gives Kelly Kare no contractual rights for the year 1991.

[2] On oral argument, we were advised that there is a criminal investigation into Kelly Kare or a related company owned by the same principal. Since we have no affidavit to this effect and are given no details, we do not give this development any consideration.

[3] In exchange for a limited restraining order, Kelly Kare has agreed to provide services to its remaining clients at least through the month of December and will not bill these clients for lost Medicaid benefits.

[4] These hearings demonstrated that, while there is a substantial factual issue critical to the injunction decision, its resolution can be

claims,[5] only three of these have sufficient materiality to require consideration.

The general standard for granting preliminary injunctive relief in this circuit is well settled. To justify the issuance of an injunction, the plaintiff must show "(a) irreparable harm and (b) either (1) likelihood of success on the merits or (2) sufficiently serious questions going to the merits to make them a fair ground for litigation and balance of hardships tipping decidedly toward the party requesting the preliminary relief." *Jackson Dairy, Inc. v. H.P. Hood & Sons, Inc.*, 596 F.2d 70, 72 (2d Cir. 1979) (per curiam). However, where the moving party seeks to stay governmental action taken in the public interest pursuant to a statutory or regulatory scheme, the less rigorous fair-grounds-for-litigation standards do not apply. *Union Carbide Agricultural Production Co. v. Costle*, 632 F.2d 1014, 1018 (2d Cir. 1980), *cert. denied*, 450 U.S. 996 (1981). Therefore, to prevail on this motion, Kelly Kare must show both that irreparable harm to it will result if the County's termination is not enjoined and that it is likely to prevail on the merits of the claims asserted.

For the purpose of this discussion, we will assume that Kelly Kare will suffer irreparable harm as a result of the County action. However, this assumption should be tempered by our observation that the termination of the Westchester County contract has no effect upon Kelly Kare's status as a state authorized Medicaid provider.

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reached from undisputed evidence. Consequently, no evidentiary hearing has been deemed necessary on the motion for preliminary injunction.

[5] One of the more transparent claims is that the contract was terminated because the company is owned by a woman. The company has been owned by a woman for the several years since it first started contracting with the County. There appear to be about four other providing companies which are female owned. There is nothing in the record to support this sex discrimination claim.

It can obtain contracts from any other County or governmental body which is willing to contract with it.

Next, Kelly Kare's likelihood of success on the merits must be assessed. The initial claim is that Kelly Kare has a property interest in the continuation of its contract. Therefore, as guaranteed by the fourteenth amendment, due process requires that a hearing be held before the contract is actually terminated.[6] We cannot recognize this claim. As noted above, the contract in question states that it is terminable without cause. Furthermore, as the County argues, if all public contracts were *per se* a property interest, the effect would be the constitutionalization of the contractual relationships of all governmental contractors. No court has yet recognized such a claim of entitlement. *See, e.g., S & D Maintenance Co., Inc. v. Goldin*, 844 F.2d 962 (2d Cir. 1988).

In response, Kelly Kare denies that it is attempting to vindicate its contract rights, claiming that the County's refusal to renew its contract deprives it of its status as a Medicaid provider. Even if Kelly Kare were correct, this circuit has not squarely declared that Medicaid providers have a property interest in continuing participation in the program. In *Plaza Health Laboratories, Inc. v. Perales*, 878 F.2d 577, 580 (2d Cir. 1989), the court held that the health care provider's interest did not rise to a level of a constitutionally protected property interest. Although the same court, three years earlier, declared that health care providers have a constitutionally protected property interest in continued participation in the Medicare and Medicaid programs, *see Patchogue Nursing Center v. Bowen*, 797 F.2d 1137, 1144-45 (2d Cir. 1986), we note that the health care provider in that case was being terminated from the program by the New York State Department of Health. But here, as men-

[6] The moving papers do not suggest the forum for this hearing, the issues to be determined, or the manner in which the dispute should be resolved.

tioned earlier, Kelly Kare's status as a Medicaid provider is not threatened—Westchester County has simply declined to renew its contract. Indeed, because Kelly Kare's status as a state authorized Medicaid provider continues, there has been no denial of a license which would normally support a due process claim for a hearing.[7]

Furthermore, although the recipients (the putative McNulla class) have a right to continued benefits, *see Goldberg v. Kelly*, 397 U.S. 254 (1970), they have no property right to demand a specific Medicaid provider, *O'Bannon v. Town Court Nursing Center*, 447 U.S. 773 (1980). Finally, we can see no possible property rights of Kelly Kare's employees that are not derivative from Kelly Kare's own status or from those of the recipients.

Kelly Kare attempts to bolster its due process claim by arguing that it also has liberty interests that are being "stigmatized" by the termination of its contract without cause. To support such a claim, the plaintiff must show that there is damage to the plaintiff's reputation resulting from the government's release of stigmatizing information that is false. *See Wisconsin v. Constantineau*, 400 U.S. 433, 437 (1971); *Senape v. Constantino*, 740 F. Supp. 249, 260 (S.D.N.Y. 1990). The County is attempting to avoid fueling such a claim by refusing to give any reason for the termination. The plaintiffs argue that the failure to give a reason also implicates liberty interests since the mere termination of a contract has negative implications. If this argument was accepted, all contract, employment, or other types of terminations, regardless of circumstances, could support a constitutional due process claim in which the propriety of the termination could always be litigated in federal court.

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[7] *See* footnote 2, *supra*. If the criminal investigation leads to a termination of Kelly Kare's status as a Medicaid provider, the situation will be different. But in that case, the appropriate defendant would be the State of New York.

The only substantial argument made by Kelly Kare, and the one on which it chiefly relies, is the claim that its contract has been terminated because of an anti-union bias on the part of the County. It seems that shortly before the contract termination, Kelly Kare gave a copy of its union contract to the County.[8] Kelly Kare argues that the relatively contemporaneous contract termination must be more than a coincidence and has to be due to an anti-union bias on the part of the County Department of Social Services.

The County disputes this vigorously.[9] It acknowledges that the County may not discriminate against its contractors for unconstitutional or impermissible reasons. *See Rutan v. Republican Party of Illinois*, —— U.S. ——, 110 S. Ct. 2719 (1990); *Golden State Transit Corp. v. City of Los Angeles*, 475 U.S. 608 (1986); *Perry v. Sindermann*, 408 U.S. 593, 597 (1972). However, the County notes that most of its employees are unionized and that some of the other Medicaid providers who contract with the County are unionized.[10] The responsible officials of the County have, by affidavit, denied any union bias or any such matters entering into their consideration of the contract termination. While the plaintiffs are, of course, not bound by such a denial, they have not made an adequate evidentiary showing of a impermissible motive so

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[8] The copy was given to document Kelly Kare's claim that it was providing free health care to its workers as required by the County and State. The contract had been in force for a couple of months.

[9] The County also argues that the Court may not even consider the issue since labor union disputes are regulated by the National Labor Relations Act, 29 U.S.C. § 160, and the plaintiffs must exhaust administrative remedies as a prerequisite for judicial review. In light of our determination on the weight of the evidence, we need not consider this interesting legal issue.

[10] We are aware that the County and at least one major union have been having severe disputes. However, there is no evidence that Kelly Kare's union, Communication Workers of America, is engaged in any disputes with the County.

as to warrant the extraordinary imposition of injunctive relief preventing the contract termination.[11] We have considered the other arguments raised by plaintiffs and find them unconvincing. Plaintiffs have not established the likelihood of success.

Consequently, on the evidence before the court at this time, the motion for a preliminary injunction must be denied. The court's earlier restraining orders are dissolved.

SO ORDERED.

Dated: White Plains, N.Y.
December 7, 1990

/s/ Gerard L. Goettel
GERARD L. GOETTEL
U.S.D.J.

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[11] As noted above, the contract, by its terms, expires at the end of the month. The plaintiffs seek not only an injunction against its early termination but the affirmative imposition of a contractual relationship for the future or until such time as the defendants can convince the court (or whatever tribunal the plaintiffs believe should conduct such a hearing) that Kelly Kare is an inadequate provider of services.

APPENDIX C

UNITED STATES COURT OF APPEALS
FOR THE SECOND CIRCUIT

At a stated term of the United States Court of Appeals for the Second Circuit, held at the United States Courthouse, in the City of New York, on the 14th day of May, one thousand nine hundred and ninety-one.

Docket Number 90-9107

KELLY KARE, LTD., *et al.*,
Plaintiffs-Appellants,

v.

ANDREW P. O'ROURKE, *et al.*,
Defendants-Appellees.

[Filed May 14, 1991]

A petition for rehearing containing a suggestion that the action be reheard in banc having been filed herein by Appellant Kelly Kare, Ltd.

Upon consideration by the panel that heard the appeal, it is

Ordered that said petition for rehearing is DENIED.

It is further noted that the suggestion for rehearing in banc has been transmitted to the judges of the court in regular active service and to any other judge that heard the appeal and that no such judge has requested that a vote be taken thereon.

/s/ Elaine B. Goldsmith
ELAINE B. GOLDSMITH
Clerk

APPENDIX D

CONSTITUTIONAL PROVISIONS, STATUTES, AND REGULATIONS INVOLVED

U.S. CONST. amend. XIV, § 1

> Section 1. All persons born or naturalized in the United States, and subject to the jurisdiction thereof, are citizens of the United States and of the State wherein they reside. No State shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any State deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws.

42 U.S.C. § 1396a(a)23(A)

> § 1396a. State plans for medical assistance
>
> (a) Contents
>
> A State plan for medical assistance must—
>
> (23) except as provided in subsection (g) of this section and in section 1396n and except in the case of Puerto Rico, the Virgin Islands, and Guam, provide that (A) any individual eligible for medical assistance (including drugs) may obtain such assistance from any institution, agency, community pharmacy, or person, qualified to perform the service or services required (including an organization which provides such services, or arranges for their availability, on a prepayment basis), who undertakes to provide him such services . . .

42 U.S.C. § 1983

> § 1983. Civil action for deprivation of rights
>
> Every person who, under color of any statute, ordinance, regulation, custom, or usage, or any State

or Territory or the District of Columbia, subjects, or causes to be subject, any citizen of the United States or other person within the jurisdiction thereof to the deprivation of any rights, privileges, or immunities secured by the Constitution and laws, shall be liable to the party injured in an action at law, suit in equity, or other proper proceeding for redress. For the purposes of this section, any Act of Congress applicable exclusively to the District of Columbia shall be considered to be a statute of the District of Columbia.

42 C.F.R. § 431.51

§ 431.51 Free choice of providers.

(a) *Basis and purpose.* This section implements section 1902(a)(23) of the Act, which provides that recipients may obtain services from any qualified Medicaid provider, and section 1915 of the Act, which provides that a State shall not be found out of compliance with section 1902(a)(23) solely by reason of certain specified allowable restrictions of this free choice (see paragraph (c) of this section and § 431.54) and which authorizes the Secretary to waive the requirements of section 1902(a)(23), and other provisions of the Act, in certain circumstances (see § 431.55).

(b) *State plan requirement.* Except as provided in paragraph (c) of this section, a State plan (except in Puerto Rico, the Virgin Islands, and Guam) must provide that any recipient may obtain Medicaid services from any institution, agency, pharmacy, person, or organization that is qualified to perform the services, including an organization that provides these services or arranges for their availability on a prepayment basis.

(c) *Limitations on applicability.* Paragraph (b) of this section does not prohibit the agency from—

(1) Establishing the fees it will pay providers for Medicaid services;

(2) Setting reasonable standards relating to the qualifications of providers; or

(3) Restricting recipients' free choice of providers in accordance with one or more of the exceptions provided for under § 431.54, or under a waiver as provided for under § 431.55.

(d) *Certification requirement.* If a State implements a project under one of the exceptions allowed under § 431.54(d), (e) or (f), it must certify to HCFA that the statutory safeguards and requirements for an exception under section 1915(a) of the Act are met. The certification must be submitted by the end of the quarter in which the State implements the project, except that the certification must be submitted prior to instituting the project to instituting the project in the case of an exception under § 431.54(d), for which the Secretary must make certain findings before the project may be initiated.

N.Y. SOC. SERV. LAW § 364(2)(b)

§ 364. Responsibility for standards

To assure that the medical care and services rendered pursuant to this title are of the highest quality and are available to all who are in need, the responsibility for establishing and maintaining standards for medical care and eligibility shall be as follows:

* * * *

2. The department of health shall be responsible for

(b) establishing and maintaining standards for all non-institutional health care and services rendered pursuant to this title, including but not limited to procedural standards relating to the revocation,

suspension, limitation or annulment of qualification for participation as a provider of care and services, on a determination that the provider is an incompetent provider of specific services or has exhibited a course of conduct which is either inconsistent with program standards and regulations or which exhibits an unwillingness to meet such standards and regulations, or is a potential threat to the public health or safety pursuant to section two hundred six of the public health law;

N.Y. COMP. CODES R. & REGS. tit. 18, § 504.7(a)

504.7 Continued enrollment termination. (a) A provider's participation in the program may be terminated by either the provider or the department upon 30 days' written notice to the other without cause.